



STATE OF TENNESSEE  
**DEPARTMENT OF COMMERCE AND INSURANCE**  
500 James Robertson Parkway, 4<sup>TH</sup> Floor  
Nashville, Tennessee 37243

NOTICE

**ATTENTION:** All insurers writing workers' compensation insurance, self insured plans and self insured groups.

Tennessee's antifraud statute, Tenn. Code Ann. §§ 56-47-101 *et seq.*, affects all workers compensation insurers, self insurers, and self insured groups. New insurers and self insured employers or self insured groups should file a plan no later than their acceptance by the Department. Insurers not intending to produce this line of business will find a form following this notice to file with the Department. A filing will be due from all companies and self insurers when and if they begin writing the line mentioned above.

**YOU MUST:**

**A. FILE AN ANTI-FRAUD PLAN**

Tenn. Code Ann. § 56-47-112 requires every workers compensation insurer – including self insurers – prepare, implement, and maintain an anti-fraud plan. The plan must be submitted for approval to:

Tennessee Department of Commerce and Insurance  
Fraud and Special Investigations Unit  
500 James Robertson Parkway, 4<sup>th</sup> Floor  
Nashville, TN 37243-5341

Each plan shall outline specific procedures to:

1. Prevent, detect, and investigate all forms of workers' compensation fraud, including:
  - (a) Fraud involving insurer's employees or producers
  - (b) Fraud resulting from misrepresentation in an application
  - (c) Fraud in renewal or rating of policies
  - (d) Data processing and computer security fraud
  - (e) Claims fraud by claimants, providers, or professional and investigative services.
2. Educate employees on fraud detection and the in house anti-fraud plan
3. Provide for the hiring of, or contracting with fraud investigators
4. Report workers' compensation fraud to appropriate law enforcement and regulatory authorities for the purpose of investigating and prosecuting perpetrators.
5. Pursue restitution for financial loss caused by fraudulent activities

To make compliance with the new law easier, we have developed an anti-fraud plan guideline and forms for your use. The model plan guidelines may be ordered, if you desire, in hard copy or diskette form. An order form is included with this notice. You must customize the plan to meet the requirements of your company and to include the specific procedures described in numbers 1. Thru 5.) above. A fraud plan that your company has in place that complies with the new law may be submitted. All companies should promptly notify and provide a copy of the plan to all their Tennessee producers and employees. At any time the plan is modified, a copy of the modified plan is to be refiled with the Tennessee Department of Commerce and Insurance, Fraud and Special Investigations Unit, at the address listed above.

#### **B. Fraud Reporting**

1. Reports of fraud dealing with company or producer fraud should be referred to:

Tennessee Department of Commerce and Insurance  
Fraud and Special Investigations Unit  
500 James Robertson Parkway, 4<sup>th</sup> Floor  
Nashville, TN 37243-5341  
Phone: (615)-253-1376 or (800) 792-7573  
Fax: (615) 532-7389

2. Reports of fraud dealing with fraudulent activities of claimants, providers, and professional services and should be reported to:

Tennessee Department of Labor and Workforce Development  
Workers' Compensation Anti-Fraud Unit  
710 James Robertson Parkway 2<sup>nd</sup> Floor  
Nashville, TN 37243-0661  
Phone: (615) 532-1836

#### **C. ANNUAL SUMMARY REPORTING**

To assure compliance with the spirit of the law an annual summary of action taken under the anti-fraud plan must be submitted to the Fraud and Special Investigations Unit by March 31 of each year. The report should include, but not be limited to:

- a. Describe anti-fraud training claims employees received
- b. Describe steps to detect fraud in company employee's and producers
- c. Describe steps to detect fraud in modulation rate by insured
- d. Describe steps to detect fraud in claims by insured employees
- e. Describe steps to detect data processing fraud;
- f. Describe steps to detect misrepresentation by consumer
- g. Summarize cases referred to appropriate authorities
- h. List the amount of monetary recoveries
- i. Discuss possible organized criminal activities

#### **D. Mandated Notice**

All printed applications for insurance, and all printed claim forms provided and required by an insurer or required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form that clearly states in substance the following:

**“It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers’ compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.”**

**All other filings and inquiries regarding these requirements should be directed to:**

Tennessee Department of Commerce and Insurance  
Fraud and Special Investigations Unit  
500 James Robertson Pkwy 4<sup>th</sup> Floor  
Nashville, TN 37253-5341  
Phone: (615)-253-1376 or (800) 792-7573  
Fax: (615) 532-7389

REGISTRATION FORM FOR  
WORKERS' COMPENSATION ANTI-FRAUD PLAN\*

Mark one box:      Original Filing                      Refiling of Modified Plan

Company Name:

\_\_\_\_\_

Contact Person:

\_\_\_\_\_

Position Title:

\_\_\_\_\_

Phone: (\_\_\_\_\_) - \_\_\_\_\_ -

\_\_\_\_\_

Location Address:

\_\_\_\_\_

City: \_\_\_\_\_ TN \_\_\_\_\_ ZIP: \_\_\_\_\_

Mailing Address:

\_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

\_\_\_\_\_

Mark one box:   ☐ Insurance Company   ☐ Self-insured Employer   ☐ Self-insured Group  
Self-insured Employer or Group are you using a TPA to manage your plan?   Yes   No

TPA Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact Person:

\_\_\_\_\_

Phone: (\_\_\_\_\_) - \_\_\_\_\_ -

\_\_\_\_\_

Signed at: \_\_\_\_\_ By: \_\_\_\_\_

Date: \_\_\_\_\_ Title \_\_\_\_\_

\*This form, or the information required by this form, must be a cover to your anti-fraud plan.

SUMMARY REPORT FORM FOR  
WORKERS' COMPENSATION ANTI-FRAUD PLAN

Company Name:

\_\_\_\_\_

Report prepared by:

\_\_\_\_\_

Firm:

\_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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Reporting period:

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1. Describe the resources committed to the combating of fraud in this reporting period  
(number of employees, investigations performed by contracted investigators,  
costs of the resources used, etc.).
2. List the number of instances and amount of fraud discovered in this reporting period.
3. List the number and amount of recovery during this reporting period.
4. Describe, in as much detail as possible, any and all discovered criminal activities of an  
organized nature.
5. List the claim costs for discovered fraud from claims activity.
6. Describe the internal activities taken to detect fraud among company employees.

THIS FORM MUST BE SIGNED AND DATED

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## WORKERS' COMPENSATION FRAUD REFERRAL FORM

Please type or print information (complete all applicable sections).

Date of Referral \_\_\_\_\_

Referral By: Insurance Co. \_\_\_\_\_ Other \_\_\_\_\_

Referring Person \_\_\_\_\_ Telephone# \_\_\_\_\_

Referred to Law Enforcement Agency: No \_\_\_ Yes \_\_\_ Who \_\_\_\_\_

### REASON FOR REFERRAL (PLEASE ATTACH RELEVANT DOCUMENTS)

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### CONTACT INFORMATION

Contact Person \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

Company Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

Type of Workers' Comp Fraud: (Please mark applicable category)

\_\_\_\_\_ Claimant/Benefits Fraud (i.e, false application, staged accident, etc.)

\_\_\_\_\_ Premium Avoidance Fraud (i.e, payroll and/or employee misclassification, etc.)

\_\_\_\_\_ Agent Theft

\_\_\_\_\_ Other \_\_\_\_\_

### LOSS INFORMATION

Date of Accident/Loss \_\_\_\_\_ Location of Accident/Loss \_\_\_\_\_

Description of Accident/Loss \_\_\_\_\_

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Insurance Claim# \_\_\_\_\_ Police Report # \_\_\_\_\_

Other Insurance Company Involved \_\_\_\_\_

Address \_\_\_\_\_

Contact Person \_\_\_\_\_ Telephone# \_\_\_\_\_

Claim # \_\_\_\_\_ Policy # \_\_\_\_\_

Value of Claim:\$ \_\_\_\_\_ Amount of Demand \_\_\_\_\_

### SUSPECT INFORMATION

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_

Weight \_\_\_\_\_ Hair \_\_\_\_\_ Eyes \_\_\_\_\_ Scars/Marks/Tattoos \_\_\_\_\_

Vehicle: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Color \_\_\_\_\_

Tag# \_\_\_\_\_ State \_\_\_\_\_ VIN# \_\_\_\_\_ Driver's License# \_\_\_\_\_ State \_\_\_\_\_

## VICTIM INFORMATION

Name of \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_ Telephone # \_\_\_\_\_  
Contact Person \_\_\_\_\_ Telephone# \_\_\_\_\_  
Name of Individual \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_

## OTHERS INVOLVED

IDENTIFY ALL PRINCIPALS AND THEIR ROLES USING THE FOLLOWING:

ADJ- Adjuster; AGT- Agent; APP- Appraiser; ATT- Attorney; CHIRO- Chiropractor;  
CLMT- Claimant; INSD- Insured; MEDOC- Medical Doctor; PASS- Passenger; PHYS-  
Physical Therapist; WIT- Witness.

Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ Role \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ Role \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ Role \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ Role \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ Role \_\_\_\_\_

## MAIL COMPLETED FORMS AND SUPPORTING DOCUMENTATION AS DIRECTED BELOW:

### EMPLOYEE FRAUD

Tennessee Department of Labor  
Attn: Ed Finchum  
Division of Workers' Compensation  
710 James Robertson Pky., 2nd Fl.  
Nashville, TN 37243-0661

### ALL OTHER FRAUD

Tenn. Dept. Of Commerce and Insurance  
Fraud Director  
Fraud and Special Investigations Unit  
500 James Robertson Pky., 4th Fl.  
Nashville, TN 37243-0574

To:

DEPARTMENT OF COMMERCE AND INSURANCE  
Fraud & Special Investigations-4th Floor  
500 James Robertson Parkway  
Nashville, TN 37243-0574

From:

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Name:

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Company:

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Address:

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City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Item	Cost	Quantity
Hard copy of the Tennessee model workers' compensation anti-fraud plan, printed on 8.5 by 11 inch paper	\$10.00	_____
Tennessee model workers' compensation anti-fraud plan on 3.5 inch disk in WordPerfect format	\$10.00	_____

Amount Enclosed \$ \_\_\_\_\_

Make checks payable to: Tennessee Department of Commerce and Insurance and enclose with copy of this form with company name and mailing address completed. Orders will be filled in the order received and in the shortest possible time.